CDC *Vital Signs* Town Hall Teleconference

Hospital Support for Breastfeeding
Q & A Transcript

August 9, 2011
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Brook Nash: Thank you, Tom. And thank you all for wonderful presentations. So, in just a moment we will ask the operator to open up all the lines for discussion and Q&A.

And as a courtesy to everyone on the call, we ask that each of you mute your phone - and you can do so by pressing star, 6 when you are not talking. And unmute your phones again by pressing star, 6.

So, Operator, can you please open all the lines now?

Coordinator: Yes, thank you. One moment please and I'll open up all the lines.

Brook Nash: Thank you.

Coordinator: You're welcome.

Brook Nash: And while the phone lines are opening, I would like to turn it over to Dr. Monroe for her initial comments and thoughts to help kick off today's discussion.

Dr. Judy Monroe: Thanks, Brook. First of all, let me congratulate Connecticut and Wyoming. I think the work that you've heard today is outstanding. And certainly gives us a way forward. As Dr. Grummer-Strawn pointed out to us, this is a win, win, win and you don't get many of those. So it's all good. Breastfeeding helps

infant and child health, it reduces cost and helps the mothers health in terms of reduction of risks for cancer and so forth.

So, you know, this is a no-brainer. This is something that the country really needs to embrace and take on. And so with that, you know, as a former state health official for all the health officials on the call today and their staff, I would say the first thing that needs to happen is that health officials need to seize the bully pulpit and get before the hospital associations or the executive boards of the hospitals. And challenge your hospitals in your states to become a Baby-Friendly hospitals.

That should happen right after this call. You guys ought to be on it. I think Connecticut and Wyoming have given us, again, a road map. So you've got the steps to go forward but first you have to get the buy in of the hospitals. And I hope if there are listeners on today from hospitals I hope you all in turn challenge your health departments to support you in this.

And so I'll kick off with the first question to folks in - for everybody out there now that's all fired and ready to take this on. The question becomes then how do you become creative around resources to help move this along. We heard from Connecticut that there was some ARRA funding that helped stimulate this.

Thoughts from our speakers or others regarding how resources might be mobilized to make this happen because this does need to happen.

Dr. Jewel Mullen: Dr. Monroe?

Dr. Judy Monroe: Yes. Hi, Jewel.

Dr. Jewel Mullen: From Connecticut. I think one of the first things we have to remember is that the resources aren't always dollars.

Dr. Judy Monroe: Yes.

Dr. Jewel Mullen: So just what - what you've just said about our - our using our positions as state health officers to talk to hospitals, is very important. Because that doesn't take anything other than a little bit of time. And there are, we talked about linking this work to WIC. We've talked about looking at policies around daycare. We've talked about comprehensive obesity efforts. And I think in part you just have to remember this. It's part of breaking down the silos and looking at the - how the work fits into the big picture. And not just see it in isolation.

Dr. Judy Monroe: Yes, that's exactly - I think that's exactly right. And, you know, and my charge there was for state health officials to take on the state organizations. But, you know, there's a role here obviously. Every local health officer can join forces with the state health officer and/or, you know, on the charge within their counties as well with their local hospitals. So there's enough work here to go around for everybody.

Dr. Jewel Mullen: And we can remind people, even those who are doing worksite wellness programs the contribution that employers can make to this.

Dr. Judy Monroe: Great point.

(Karen Rimly): Judy?

Dr. Judy Monroe: Yes?

(Karen Rimly): This is (Karen Rimly).

Dr. Judy Monroe: Hey, (Karen).

(Karen Rimly): A couple of things too to add is I'm hoping that on a national level, we're working with the national hospital association because it's effective to work from above and below.

Because I think if the National Hospital Association adopted this as an important it would just support all the work we do. The other thing that we're trying to do here in Virginia that I encourage other state health officials or people to talk is with their health plan. Because if the health plan has it as a part of their pay-for-performance program or part of their requirements as they contract with birthing hospitals to be a Baby-Friendly hospital.

Again, that's another way to (mud) each box to get people engaged and involved. Because I think about - not what you would consider your first most likely partner but maybe a very important partner. With the health plans about to - cost make a big difference with them.

Dr. Judy Monroe: Those are excellent points, (Karen). And, you know, I'm going Dr.Grummer-Strawn, Laurence, are you on?

Dr. Laurence Grummer-Strawn: Yes, I'm here.

Dr. Judy Monroe: In your division are you all - where's the National Hospital Association stand on this?

Brook Nash: Operator, could you please mute everybody?

Dr. Judy Monroe: We're getting interference here.

((Crosstalk))

Brook Nash: Dr. Grummer-Strawn can you hear better now?

Dr. Laurence Grummer-Strawn: Not a whole lot better but we can just try and speak over it, I guess.

Dr. Judy Monroe: There you go - now you're clear.

Dr. Laurence Grummer-Strawn: Now it sounds much better.

Dr. Judy Monroe: There we go.

Dr. Laurence Grummer-Strawn: With the National Hospital Association, their answer has been that they don't really work at the level of quality of care that AHA is much more about kind of the business of hospitals and their responses as to what to do. But that they don't really take on much of - trying to change care. That's really what joint commission would do with the quality of care, another care initiative.

Dr. Laurence Grummer-Strawn: If I could respond to what (Karen) was talking about.

Dr. Judy Monroe: Could you mute your phones please, or not talk over the speaker please. Thank you.

Dr. Laurence Grummer-Strawn: I'll also comment on what (Karen) was talking about with the different performance in health plan. Oregon has pulled together many of its healthcare third party payers, I think they've got about 90% of the market

in a (unintelligible) to talk about how they can do things differently to improve obesity rates.

And they have taken on this kind of charge toward working (unintelligible) put in place yet. But they're really seeing this as a key priority for them.

It's also a possibility for Medicaid at state level to try out (unintelligible) improved quality in the hospital. If they were to create some kind of a differential, either higher pay for the hospitals that are designated as Baby-Friendly or (unintelligible) for all the ones who are not. Just kind of create a wedge in there to create that incentive.

Brook Nash: Thank you, Dr. Grummer-Strawn. Are there any additional questions?

Coordinator: Yes, we have a question from Miami-Dade County Health Department.

Woman: What we'd like to know, we're calling from the WIC and Nutrition Program. And what is the working relationship that you both have had with your local WIC programs with the peer counselors?

And also the (unintelligible) going through the Medicaid process. If you can tell us a little bit more about that it would be appreciated.

Brook Nash: Thank you, Miami-Dade. Jewel or Tom any response to that how you've been working with your peer counselors and WIC?

Dr. Jewel Mullen I have the program manager for the Connecticut Initiative, Stephanie Mendelick here. So I'm going to let her answer that question.

Brook Nash: Perfect.

Stephanie Mendelick: I think the best way to answer the question here at the state level. This program currently resides within the Nutrition, Physical Activity, and Obesity Program but we work very closely with the WIC program at the state level. So they help disseminate that message down. And in part when we first introduced this initiative to the hospitals there was a selection process. And 13 hospitals applied to participate and we gave preference to hospitals who participated in the WIC peer counseling program as a way to encourage their participation in the initiative.

Brook Nash: Great, Tom, anything else to add?

Thomas Forslund: In Wyoming, the person who oversees our program is the State Supervisor in the WIC program. So she has it integrated throughout her program.

Woman: Do you know what capacity the peer counselors are being used at - at the local level? In the initiative?

Thomas Forslund: I can not answer that. But I can certainly put you in touch with the person who oversees that if you're interested.

Woman: Yes, that would be great.

Stephanie Mendelick: This is Stephanie from Connecticut. I know that our peer counselors are aware of the program - and involved in the program at the local level.

Woman: How involved?

Brook Nash: Are there any additional questions around using the peer counselors?

Coordinator: Once again, if you would like to ask a question, please press star then 1.

Brook Nash: In the meantime if there are any questions, so to follow-up with any of other speakers to get more information about their programs. Just send us an email. You'll see it on the last slide of this presentation, it's mailto:ostltsfeedback@cdc.gov. And we'll be happy to connect you all with the speakers or any additional information.

Are there any other questions?

Coordinator: We have a question from (Jose Rodriguez).

(Jose Rodriquez): No ask a question, mostly a comment. I think this a great initiative. And I congratulate the presentations about the Wyoming and Connecticut. But I think that based on the fact 25% of the childbearing women are now employed. And that they comprise at least 48% of the work force that we should then take the next step and link this initiative to make a business case for breastfeeding because they might learn and they might nurse and breastfeed at the hospital. But if they don't find a workplace that is friendly for them to continue to breastfeed. Then that's going to hurt our efforts to continue with this initiative.

Brook Nash: That is a great point Jose. Very nicely put.

(Jose Rodriquez): Thanks.

Thomas Forslund: I'll add on to that. The Portable Care Act actually set out that it is now the law that hourly wage employees that the employer must provide accommodations for lactation in the workplace. To at least express breast milk, they must have

time to express as well as a place other than a bathroom to express breast milk at the workplace.

In addition, the Surgeon General's call to action to support breastfeeding that came out in January called for a number of steps for employers to improve their support for lactation at the workplace.

Brook Nash: Very good, thank you.

Coordinator: The next question's from (Dr. David Grines).

(Dr. David Grines): Hi, I wonder if there is any evidence base support for some of this. It seems a little too simplistic to me that 48 hours in the hospital is going to make that much of difference in a mother's decision about breastfeeding. Most of my patients have made that decision a long time before they reached the hospital.

And I found that almost all hospitals that I've ever been associated with have been very breastfeeding supportive even though they may not qualify with these then different steps, you know, for being Baby-Friendly. And I wonder if we're not jumping on a band wagon without having the evidence to support this. I think we need to be supportive of all moms who want to breastfeed but I'm not sure there's an evidence based science there to support that if you happen to go to a hospital that's labeled Baby-Friendly that your first grader when they hit first grade is more or less likely to be obese.

Does anyone know of any evidence based to support that?

Brook Nash: Dr. Grummer-Strawn?

Dr. Laurence Grummer-Strawn: I'm going to take that question (David), yes, I think there is a pretty good evidence base for it. What you really have to look at is we're not talking about getting women to choose to breastfeed. You're absolutely right that the decision whether or not she wants to breastfeed is probably made prenatally and while the hospital may be able to sway a few women who were kind of on the fence.

That's really not what we're talking about here. This is primarily about women who did choose to breastfeed did they get off to a good start that they actually can do it. And what we have found is that that first 48 hour period is a critical time because that newborn is having to learn how to breastfeed.

And if they don't get the right kind of support in terms of professionals checking that they're doing it right that they can have frequent contact with one another. That she can learn the cues of the baby as when the baby needs to feed that they're not being supplemented so the baby's getting confused with getting some supplements and she doesn't start producing milk as quickly. You know, we get delayed lacto genesis.

All those physiological factors have a critical impact on her ability to continue breastfeeding. There's an article published in Pediatrics in 2008 that showed a huge differential. It was actually a 13 times the odds ratio for those who got all of these optimal practices that they were able to study

compared to those who didn't get those optimal practices at being able to continue breastfeeding for six weeks. We have randomized controlled trials that have gone in and intervened with hospitals. These kind of group randomized efforts and shown dramatic impacts on the continuation of exclusive breastfeeding in those hospitals that got the intervention versus those that were routine care.

We have interventions that have gone in just to really focus in on exclusive breastfeeding in the hospital and seen continued effects on the duration of breastfeeding out to nine months. I think the evidence is there.

Brook Nash: Great explanation. So we have time for maybe one or two more questions.

Coordinator: Thank you the next questions from (Carmen Thompson).

Brook Nash: (Carmen) this is Brook again, could you repeat your question, we have a hard time hearing you.

(Carmen Thompson): Okay, I wanted to know who receives the certified lactation counselor training?

Brook Nash: Yes, Jewel I think was that you?

Dr. Jewel Mullen: No, it's in Wyoming.

Thomas Forslund: Sorry, I didn't hear.

Brook Nash: Tom the question was who receives the certified lactation counselor training as a part of your program? The authority in the hospital or...

Thomas Forslund: It's, let me get the AP information here but it's - it's through - it's not at the hospital per see it's continuing. Let's see - see the Healthy Children Project provides the basic annual certified lactation counselor training. Then in advance the LC training is conducted in alternate years. So it's the Healthy Children Project which is a separate not for profit group.

Dr. Laurence Grummer-Strawn: The CLC training typically has been given for nurses and WIC has it used it a fair amount to train their paraprofessionals within the WIC program.

(Carmen Thompson): Thank you.

Brook Nash: Thank you and last question.

Coordinator: Is from (Susan Landers).

(Susan Landers): Can you hear me?

Brook Nash: We can.

(Susan Landers): I'm in Austin Texas and we have been monitoring rates of exclusive breastfeeding at hospital discharge at our six birthing sites of one hospital network. And the very process of monitoring the use of formula supplementation in which babies get supplemented and which babies start breastfeeding and go home exclusively breastfeeding has focused attention on a process that is crucial and one of the first steps in becoming Baby-Friendly.

My question is because exclusive breastfeeding at hospital discharge is part of the prenatal care core measures that are being tracked by the Joint Commission, what can we do - CDC or other Federal agencies - to encourage Joint Commission to make these prenatal care core measures mandatory and not voluntary.

I feel like hospitals march to the drum of Joint Commission and if we could do something at the Federal level. Make a strong recommendation about

hospital's tracking rates of exclusive breastfeeding it would show people what the problems are in most of these maternity centers.

Brook Nash: That's a great question (Susan).

Dr. Laurence Grummer-Strawn: Thank you, (Susan). We've been having a lot of discussions with Joint Commission around that same question. Mandatory is always a difficult hurdle to get to. Joint Commission tries not make things mandatory but tries to give some flexibility and so what they've made mandatory is that hospitals need to report on a minimum of four of the core measure sets. But they don't tell them which ones they have to be.

We've talked to them about ways to incentive that hospitals are providing maternity care would have good reason that they would want to choose the prenatal care core set. We've also talked about the fact that often times they'll choose a core set on the basis that well they have to report those measures somewhere else anyway. And so if they've already got in their computer systems that are churning out the data it's a lot easier to report on those then the perinatal care set that actually has five measures within it.

So we're looking to - are there other places that we also ought to be reporting so that they can kind of kill two birds with one stone looking for options like that. And as I say Joint Commission is looking at their whole structure of how they run the core set.

(Susan Landers): Good.

Brook Nash: Thank you and unfortunately we are running out of time so I apologize to those who had questions in the queue but I think we will all be leaving here charged. And if you're on the public health side, we encourage you to reach

out to the healthcare side and vice versa. And again before we close if you can take a moment to look at the last slide in the PowerPoint presentation that is where you can find a number of links to help you integrate your *Vital Signs* into your Web site and social media channels for free.

So, for an example, you can become fan of us on Facebook or follow us on Twitter. You can also syndicate *Vital Signs* so that it automatically appears on your Web site for free. As well as download interactive buttons and banners to use on your site.

So again if you have any questions, if you need some assistance with any of that, just send an email to mailto:ostltsfeedback@cdc.gov.

In addition, on the last slide is a link for you to email us your feedback, so again, just went over that email address. We'd love to hear from you all. We'd love to get feedback and we plan for future teleconferences. So lastly I want to thank all of our speakers.

A big round of applause to Thomas Forslund, Dr. Laurence Grummer-Strawn, and Dr. Jewel Mullen for excellent presentations as well as their work to promote breastfeeding in their states.

And thank you for joining, thank you to everyone for joining the call today. And please mark your calendar for the next *Vital Signs* Town Hall. It will be September 13 and we'll be discussing smoking and tobacco use. Thank you all, have a good afternoon.